Mental Disabilities Board of Visitors

SITE REVIEW REPORT

MONTANA STATE HOSPITAL

Warm Springs, Montana

November 13, 14, 2003

Gene Haire

Gene Haire, Executive Director

February 20, 2004

Date

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Site Review Report
Montana State Hospital
November 13, 14, 2003

INTRODUCTION

- **Mental Health Facility reviewed**

  Montana State Hospital (MSH)
  Warm Springs, Montana

  Ed Amberg, Hospital Administrator

- **Reviewed by**

  Mental Disabilities Board of Visitors (BOV)

- **BOV review team**

  Board members: Steve Cahill, LCSW - Chairman
  Kathleen Driscoll – Vice Chair
  Joan-Nell Macfadden

  Consultants: Bill Docktor, PharmD
  Nathan Munn, MD
  Irene Walters, RN

  Staff: Gene Haire, Executive Director

- **Date of review**

  11 / 13, 14 / 03

- **Authority for review**

  Montana Codes Annotated, 53-21-104

- **Purpose of review**

  1) To assess the degree to which the services provided by MSH are humane, decent, comprehensive, and of high quality.
  2) To recognize excellent services.
  3) To make recommendations to MSH for improvement of services.

4) To report to the Governor regarding the status of services provided by MSH.

OVERVIEW

- **Service type** (from MSH mission statement)

  "The mission of Montana State Hospital is to provide quality psychiatric evaluation, treatment, and rehabilitation services for adults with severe mental illness."

- **Catchment area**

  State of Montana

- **Review process**

  - Interviews with MSH staff.
  - Interviews with MSH patients.
  - Review of treatment records and written descriptions of treatment services.
  - Inspection of facilities.

- **Services Reviewed**

  - Psychiatric Services
  - Primary Care Medical Services
  - Pharmacy Services
  - Medications
  - Nursing Services
  - Psychology Services
  - Social Work Services
  - Rehabilitation Services
  - Chemical Dependency Services
  - Food Service

- **Functions Reviewed**

  - Treatment Teams
  - Seclusion and Restraint
  - Abuse and Neglect Allegations
  - Involuntary Medication Review Board
  - Treatment Planning, Implementation, and Documentation

ASSESSMENT OF SERVICES

Psychiatric Services

- **Brief overview of services**:

  - MSH has six psychiatrist slots and one advance practice registered nurse (APRN) slot. Currently there are five full time psychiatrists, one full time APRN, and one locum tenens psychiatrist. One full time psychiatrist is slated to replace the locum tenens in April 2004. This is the first time that all MSH psychiatrist positions have been filled.
  - Psychiatrists and APRN prescribe medications and function as clinical leaders.

- **Review format**:

  Interviews with: Medical Director and two psychiatrists.

- **Strengths:**

  - The psychiatrists provide excellent psychiatric care to large numbers of patients with very challenging clinical and behavioral presentations.
  - Psychiatrists are vitally active leaders on treatment teams.

- **Areas of concern:**

  - None

- **Questions:**

  - None

- **Suggestions:**

  - None

- **Recommendations:**

  - None

Primary Care Medical Services

- **Brief overview of services**:

  Two full-time physicians and one 0.40 FTE dentist provide for the physical health medical needs of patients.

- **Review format**:

Interviews with: Primary Care Physician

- **Strengths:**
  - Patients receive good primary medical care. When necessary and medically indicated, patients are transferred to off-grounds treatment facilities.
  - Medical needs rounds conducted on each unit daily.

- **Areas of concern:**
  - None

- **Questions:**
  - None

- **Suggestions:**
  - None

- **Recommendations:**
  - None

Pharmacy Services

- **Brief overview of services**:

  The Departments of Public Health and Human Services and Corrections jointly contract with McKesson Med Management for pharmacy services in a number of state facilities, including MSH. The pharmacy has three full-time pharmacists and one part-time pharmacist. Medications are supplied as unit dose for each patient twice per week. Scheduled medications are provided in blister cards with a continuous inventory system and sign out system. Medications for the transitional units are provided in vials as a weekly supply.

- **Review format**:
  - Interviews with Pharmacist
  - Tour of pharmacy

- **Strengths:**
  - The temperature control system has been fixed.
  - General building/facility upkeep has improved.
  - Good working relationship between nurses and pharmacy.

- **Areas of concern:**
  - None

- **Questions:**
  - None

- **Suggestions:**
  - None
- **Recommendations:**
  - None

Medication

- **Review format**:
  - Interviews with: Pharmacist, Medical Director, Nursing Director
  - Chart review
- **Strengths:**
  - Medication management is clinically appropriate and well monitored.
- **Areas of concern:**
  - None
- **Questions:**
  - None
- **Suggestions:**
  - Based on many years of reviewing MSH medication management, it appears to the BOV pharmacology consultant that the use of PRN medications is increasing. BOV suggests that the MSH Pharmacy and Therapeutics Committee evaluate the use of PRN medications to determine whether, in fact, it is increasing and if so, to determine the reason.
- **Recommendations:**
  - None

Nursing Services

- **Brief overview of services** :

  Nursing Services Department includes registered psychiatric nurses, licensed practical nurses, and Psychiatric Technicians. The Nursing Services Department provides all daily direct medical and mental health nursing care.

- **Review format** :
  - Interviews with Director of Nursing, Nursing Supervisors, RNs, LPNs, and Psychiatric Technicians.
  - Unit observation.
  - Review of nursing staff documentation.
- **Strengths:**

- Good working relationships with Montana Tech, Carroll College, and Salish Kootenai Community College provides internships to students and recruitment pool for MSH.
- Flexibility in scheduling of nursing staff allows staff to pursue educational advancement.
- Clear delineation of Psychiatric Technician job duties and responsibilities. Psychiatric Technician training has resulted in increased professionalism and increased level of expectation. Psychiatric Technicians are active participants in treatment teams.
- Good improvement in the clarity of expectations of Psychiatric Technicians.
- Good improvement in establishment of Psychiatric Technicians' treatment role.
- Good improvement in the clarity of nurse managers' active supervision of Psychiatric Technicians.
- Crisis intervention interview and plan are excellent proactive tools for patient and staff.
- Treatment unit teams display strong sense of ownership, pride and commitment to the work they do.
- Patients report feeling respect and concern from nursing staff.
- Group content is practical and useful. Staff demonstrates flexibility in meeting individual patient needs and learning styles.
- Staff resourceful in providing diversion activities in overcrowded treatment unit situations.
- Psychiatric Technicians and Nurses function as co-leaders in a number of groups. This has contributed significantly to establishing a tangible treatment role for direct care staff and to establishing a coordinated approach that crosses former boundaries between the Nursing Department and other clinical departments.

- **Areas of concern:**

  - None

- **Questions:**

  - Many groups are geared toward the client that stays at least six weeks. Would it be helpful to develop a short track of educational materials for patients whose hospitalization is briefer?

- **Suggestions:**

  - None

- **Recommendations:**

  - None

Psychology Services

- **Brief overview of services**:

  Seven full time Ph.D. psychologists provide an impressive array of psychological services.

  - forensic evaluations
  - diagnostic evaluations
  - neuropsychological screening evaluations
  - psycho-sexual evaluations
  - capacity evaluations
  - polygraph evaluations
  - individual and group therapy
  - behavioral management plans
  - psycho-educational treatments
  - staff, patient, and family consultations
  - staff development and training
  - program development

- **Review format**:

- Group discussion between BOV team and psychologists
- Interview with Psychology Department Chief
- Interview with one individual psychologist

- **Strengths:**

  - There is a clear camaraderie and mutual professional and personal respect among the psychologists.
  - Psychologists have worked to involve Psychiatric Technicians and Nurses as co-leaders in groups. This has contributed significantly to establishing a tangible treatment role for direct care staff and to establishing a coordinated approach that crosses former boundaries between the Nursing Department and the Psychology Department.
  - Psychologists meet individually with patients as referred on a scheduled basis.

  ❋ **Resident Council** – The Chief of the Psychology Department advises and mentors the Resident Council. This council is an excellent innovation that empowers patients to elect peer representatives who provide information and support to patients and give MSH recommendations and feedback about hospital operations.

- **Areas of concern:**

  - None

- **Questions:**

  - None

- **Suggestions:**

  - None

- **Recommendations:**

  - None

Social Work Services

- **Brief overview of services**:

  Thirteen social workers and the Chief of the Social Work Department provide coordination between hospital and community resources for patients, are part of the unit treatment teams, and provide limited clinical services.

- **Review format** :

  Interviews with: Social Workers, Chief of the Social Work Department / Admissions Coordinator

- **Strengths:**

  - All of the social workers at MSH are experienced professionals who provide quality services to patients and provide a solid foundation and continuity.
  - The Chief of the Social Work Department's 28 years of experience, depth of knowledge, and well-developed communication network with community resources statewide is clearly evident in the well-organized and rational admission process.

- **Areas of concern:**

- Concerns that arose in the course of discussions with social workers and the Chief of the Social Work Department / Admissions Coordinator have to do with system dynamics, not social work services. Some of these concerns will be addressed under SYSTEM CAPACITY.

- **Questions:**

  - None

- **Suggestions:**

  - None

- **Recommendations:**

  - None

Rehabilitation Services

- **Brief overview of services**:

  - 2 Occupational Therapists
  - 3 Recreation Therapists
  - 2 Vocational Therapists
  - 2 Teachers
  - 2 Chemical Dependency Counselors (Chemical Dependency services reviewed below)
  - 4 Rehabilitation Aides

  Provide a variety of services in the areas of occupational, recreation, and vocational therapy, and basic education.

- **Review format**:

  Interviews with: Rehabilitation Department Chief

- **Strengths:**

  - Impressive array of Rehabilitation services in all areas.
  - Therapeutic Learning Center is an active hub of support and activity.

- **Areas of concern:**

  - None

- **Questions:**

  - None

- **Suggestions:**

  - None

- **Recommendations:**

  - None

Chemical Dependency Services

- **Brief overview of services**:

  Two Certified Chemical Dependency (CD) Counselors provide a variety of services including "dual diagnosis" groups for persons with co-occurring mental illness and chemical use disorders.

- **Review format**:

  Interviews with: CD Counselors

- **Strengths:**

  - Counselors are knowledgeable, enthusiastic, and clearly care about the patients with whom they work.
  - Good array of groups, including the 'Co-Occurring Psycho-educational Group' run by one of the CD Counselors and a psychology intern.
  - MSH has a good foundation on which to build increased integration of treatment for individuals with co-occurring mental illness and chemical use disorders.

- **Areas of concern:**

  - There is much opportunity for increasing the focus on comprehensively assessing the presence of and integrating the treatment for individuals with co-occurring mental illness and chemical use disorders.

- **Questions:**

  - None

- **Suggestions:**

  - None

- **Recommendations:**

1) To the greatest degree possible pending implementation of a fully integrated "co-occurring disorders" continuum of care per guidelines being developed by AMDD:
   (a) specifically identify in initial assessments each patient who has a co-occurring mental illness and chemical use disorder;
   (b) develop treatment plans for these patients that integrate treatment for the co-occurring disorders;
   (c) conduct all counseling and treatment activities within the structure of an integrated treatment plan.

Food Service

- **Review format**:

  - Interviews with Food Service Manager
  - Observation of food service operation.

- **Strengths:**

  - Passionate, innovative Manager and Nutritionist.
  - Good support from MSH Administrator for Food Service innovations.

- Staff “go the extra mile” to meet the needs and desires of patients.
- Food Service operates a ‘party program’ providing a monthly special meal, birthday party, etc. to units monthly on request.
- Cook-chill food arrives in bulk instead of on individual trays. This is an improvement and allows MSH Food Service staff to prepare and offer food in a little less institutionalized format.
- When needed, food is made available to patients on the treatment units.
- Canteen has snacks available for purchase similar to those available in a convenience store.

- **Areas of concern:**

  - None

- **Questions:**

  - None

- **Suggestions:**

  - None

- **Recommendations:**

  - None

ASSESSMENT OF FUNCTIONS and ENVIRONMENTAL ISSUES

Treatment Teams

- **Brief overview**:

  - Montana State Hospital is divided up into three Treatment Teams:

    A Unit
    B Unit and PRU
    D and E Unit

  - Each Treatment Team is led by a Team Leader, Psychiatrist(s), and Nursing Supervisor
  - Other team members include psychologists, social workers, nursing staff (Psychiatric Technicians, LPNs, and RNs), and Rehabilitation staff.
  - Treatment Teams formulate initial treatment plans and plan revisions, and meet daily to assess treatment needs and plan treatment activities for patients.
  - Treatment Team members are responsible for implementing and documenting treatment interventions.

- **Review format**:

  Interviews with Treatment Team members from all disciplines.

- **Strengths:**

  - Treatment Teams have coalesced under the leadership of Team Leaders, Psychiatrists, and Nursing Supervisors to become dynamic and effective.
  - Psychiatric Technicians have been brought into the treatment planning process as team members.
  - A “Case Coordinator” concept has been implemented that designates a mental health professional to be responsible to meet individually with each patient either weekly or biweekly

depending on acuity. This has greatly increased patients' feelings of being valued as individuals and allows for greater insight by treatment teams for patients' feelings and needs.

- **Areas of concern:**
  - None
- **Questions:**
  - None
- **Suggestions:**
  - None
- **Recommendations:**
  - None

Clinical Pathways

- **Brief overview**:
  - Over the past several years, all clinical staff have contributed to a multidisciplinary effort to develop three clinical "pathways" : (1) Coping Pathway utilizes the Dialectic Behavioral Therapy approach [even though this approach was originally designed to treat Borderline Personality Disorder, MSH staff has found it to be effective with most diagnoses]; (2) Co-Occurring Disorders Pathway (mental illness and chemical use disorders); (3) Social and Independent Living Skills Pathway. The Pathway approach provides an excellent overarching framework for the clinical work with patients at MSH. At the time of this review, there were 18 non-duplicated groups in place throughout the week, with several groups occurring multiple times per week.
- **Review format**:
  - Interviews with clinical staff in all departments.
- **Strengths:**
  - The "pathway" approach has greatly improved clinical services to patients.
- **Areas of concern:**
  - None
- **Questions:**
  - None
- **Suggestions:**
  - None
- **Recommendations:**

- None

Seclusion and Restraint

- **Brief overview**:

  Seclusion and restraint are used in situations where a patient's behavior is determined to be dangerous to him/herself and/or other people.

- **Review format**:

  - Interviews with Director of Quality Improvement (QI)
  - Ongoing observation by two full time BOV staff (Attorney and Paralegal/Advocate).
  - Review of seclusion and restraint policy and procedure, Seclusion and Restraint Review Committee minutes, sample of Quality Improvement reports, clinical record, and review of the MSH 'Patient and Staff Safety Plan' – a plan to reduce the use of restraint and seclusion.

- **Strengths:**

  - MSH leaders participated in the conference Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint this past summer. A representative from AMDD and the BOV Attorney went with the MSH team and participated in the conference. MSH administration and clinical staff have prioritized the reduction of seclusion and restraint and are beginning to implement new policies, practices, and training designed to achieve this goal.

    The Administrator and management team deserves great credit for committing MSH to this effort.

  - Both the number and duration of restraint and seclusion events have been significantly reduced in the past two years.
  - Criteria for release from seclusion have been redefined so as to be less controlling and more supportive of patients.
  - An increased focus in MANDT training on non-physical intervention and de-escalation and the increased use of 1:1 staff for upset patients have both contributed to the decreased use of physical interventions.
  - Staff who implement seclusions and restraints do so in a professional manner. When a patient is in
    seclusion or restraint, he/she is treated with kindness and respect by staff.
  - Patients who are put into seclusion or restraint frequently are "flagged" and treatment teams work to adjust approaches with these patients.
  - Psychiatrists and Nurses are doing an excellent job of debriefing seclusion and restraint events with staff. The Medical Director and the Nursing Director have developed a very good debriefing tool to be used (1) within one hour of a seclusion or restraint event by supervisors, and (2) within one day of a seclusion or restraint event by the Seclusion and Restraint Review Committee with all individuals involved – including the patient.
  - Director of Quality Improvement is knowledgeable about seclusion and restraint and the QI process relative to reducing MSH's use of seclusion and restraint.
  - QI Department follows a solid procedure for gathering and evaluating data relative to the use of seclusion and restraint.
  - MSH is a member of the Western States Psychiatric State Hospital Association and collaborates with other hospitals in comparing seclusion and restraint use.
  - The Seclusion and Restraint Review Committee uses a good review tool that focuses on critical aspects of seclusion and restraint events that may promote better training by identifying patterns of deficiency in the use of seclusion and restraint.
  - MSH is creating a room in PRU designed as a place where patients can go to calm down, relax, and get away from the stimulus on the unit.

- **Areas of concern:**

  - Some staff at all levels report feeling vulnerable as MSH pursues the goal of decreasing the use of seclusion and restraint.
  - The lack of quiet places and the overcrowding, especially on PRU, contributes to the use of seclusion and restraint. MSH statistics show that as the PRU census is reduced, seclusion and restraint is reduced.

- **Questions:**

  - Are supervisors sometimes too busy to be adequately involved in overseeing direct care staff as events escalate toward seclusion or restraint?
  - Are all direct care staff clear about observation requirements when patients are in seclusion or restraint?

- **Suggestions:**

  - Clarify expectations vs. practice in how continual observation is provided during restraint and seclusion.
  - Improve consistency in charting of debriefing between patients and staff after seclusion or restraint episodes.
  - In staff training relative to seclusion and restraint, increase the use of roleplay, discussion of hypothetical situations, and specific alternative tools for direct care staff.

- **Recommendations:**

  - None

Abuse and Neglect Allegations

- **Review format**:

  - Interviews with MSH Administrator, Director of Nursing, Director of Quality Improvement (QI), ongoing observation by two full time BOV staff (Attorney and Paralegal/Advocate).

- **Strengths:**

  - Allegations of abuse and neglect of patients by staff have been reduced in the past two years. Prior to FY 2003, the BOV office received several allegations per month. In FY 2003, there were a total of 6.
  - The physical environment of the new hospital, the increased professionalism of direct care staff, the increased cohesion of treatment teams, the expansion of treatment service offerings, and the leadership from the Administrator and all department managers have contributed to the reduction of allegations of abuse and neglect of patients by staff.

  This phenomenon is reflective of the clear and obvious improvement in the overall treatment environment and in the day-to-day relationship between staff and patients. MSH and its administrative and clinical leaders – as well as other staff at all levels – are to be commended for persistently pursuing this significant cultural change.

- **Areas of concern:**

  - None

- **Questions:**
  - None
- **Suggestions:**
  - None
- **Recommendations:**
  - None

Involuntary Medication Review Board (IMRB)

- **Brief overview of medication administered against patients' wishes at MSH (per 53-21-127(6), MCA 2003)**:

  Most commitment orders include court authorization for the Medical Director to administer medications to individual patients against their wishes. When a treating psychiatrist believes that a patient must take medications despite his/her refusal to do so voluntarily, the psychiatrist makes a written request for approval to the Involuntary Medication Review Board. It is MSH policy that IMRB reviews occur prior to such administration. The Board considers the request and either approves or denies the request. The Board also reviews extensions of this approval at 14 and 90 days following the initial approval.

  The IMRB consists of one psychiatrist who acts as the chair, the treating psychiatrist, a registered or licensed practical nurse, and one person who is not an employee of MSH. BOV, acting as the patients' attorney, receives notice of each review and may attend to give "testimony and evidence". BOV always attends IMRB review meetings.

- **Review format**:
  - Ongoing observation and participation of two full time BOV staff (Attorney and Paralegal/Advocate).
- **Strengths:**
  - This IMRB process is used effectively and appropriately. It is sensitive to patient rights and concerns and holds physicians accountable for attempting alternatives to involuntary medication and for moving away from involuntary medication as soon as possible. Each review involves a thoughtful discussion of treatment needs and alternatives to administration of medications to patients against their wishes.
- **Areas of concern:**
  - None
- **Questions:**
  - None
- **Suggestions:**
  - None
- **Recommendations:**

- None

Treatment Planning, Implementation, and Documentation

- **Brief overview of treatment planning, implementation, and documentation:**

  Each unit treatment team formulates initial treatment plans and establishes responsibilities for implementing and documenting treatment activities.

- **Review format**:

  Review of clinical record

- **Strengths:**

  - MSH has a good initial treatment planning process and works continually on improving implementation and documentation of treatment interventions.
  - Each treatment team brings a significant depth of clinical knowledge and experience to bear on the treatment planning and implementation process.
  - A treatment plan review committee is in place and has contributed greatly to improvements.
  - Good psychiatric admission evaluations.
  - Good professional nursing documentation.
  - MSH is moving forward in the implementation of a sophisticated electronic charting system that appears to have great potential.

- **Areas of concern:**
  - None

- **Questions:**
  - None

- **Suggestions:**

  - Work on increasing specificity of intervention statements.
  - Work on increasing specificity of discharge criteria statements.
  - Work on increasing consistency in referencing treatment objectives in service documentation.
  - Develop a more in-depth tool to assess chemical use.

- **Recommendations:**

  - None

Forensic Unit Outdoor Access

- **Areas of concern:**

  - The forensic unit outdoor area for patients to go outside and get some exercise and fresh air is too small.

- **Suggestions:**

  - Do everything possible to expand the outdoor exercise area on the forensic unit.

Overcrowding on PRU

- **Areas of concern:**

  - The Psychosocial Rehabilitation Unit (PRU) is the most crowded unit. This unit typically is close to or at its capacity of 60, which necessitates housing patients four to a room in a manner that does not allow for adequate space or privacy. The atmosphere on PRU is extremely active – bordering on chaotic. Even though MSH staff work hard to ameliorate the effects of this overcrowding, (plans are underway to create a "quiet room" where patients can go to get away from the noise and activity of the unit; to build additional showers, etc) this is not an acceptable environment for psychiatric treatment and recovery. Since admission numbers are significantly up from historical levels as stated above, MSH must juggle patients from the intake/acute unit (A Unit) to PRU to make room for constantly arriving new patients.

- **Suggestions:**

  - Do everything possible to address the overcrowding situation on PRU.

SYSTEM CAPACITY

Overcrowding at MSH

The MSH census has been in excess of the facility's design capacity since the day the new hospital opened its doors in August 2000. The determination of the size of the new hospital was largely arbitrary, relying on educated guesses and managed care speculation, instead of comprehensive study of the number of adults in Montana with serious mental illness and the commensurate current and future needs *of the entire system*. The average daily census has increased from 159 in FY 2000 to 189 through November of FY 2004. The number of admissions annually has increased from 466 in FY 2000 to a projected 626 in FY 2004 - based on admissions through November 2003. (The average number of annual admissions from FY 1993 through FY 1999 was 375.)

The trend in forensic admissions at MSH has had a significant impact on overall census. From FY 1993 through FY 2003, the percentage of forensic patients relative to the total hospital census has increased from 18% to 29%. Except for two minor dips in numbers in 1994 and 2000, the total number of forensic patients at MSH has increased from 27 in FY 1993 to 53 in FY 2003.

BOV believes that a primary cause of the overcrowding crisis at MSH is the absence of accurate measurement of the number of adults with serious mental illness in Montana. This has resulted in an incomplete understanding of system-wide needs; an absence of long range, need-based system design; and, underdevelopment and under funding of community-based treatment services. It is imperative that, in addressing the MSH overcrowding issue, legislative / funding strategies address development of necessary, "best practice", outcome-driven community services – and not just treat the symptom of MSH crowding by adding beds there.

Admissions To / Discharges From MSH

In the current system, several community entities – primarily mental health centers and community psychiatric hospitals, in conjunction with the judicial system under the structure of Title 53, Chapter 21, Montana Codes Annotated – initiate and control the process that leads to admissions to MSH. Even though MSH is not the only venue to which involuntarily committed individuals may be sent for treatment by a district court, MSH is the designated venue in virtually all commitments.

MSH has no role in this decision-making process. Neither the current census nor the availability of beds can preclude a court from sending an individual to MSH.

BOV supports the MSH position that it should be a participant in the decision making process that leads to patients being admitted. However, this participation should be incorporated into the larger

context of system capacity and should focus on determination of the most appropriate level of care in each case.

"Adult Transitional Shelter Care Unit"

As a result of the overcrowding at MSH, the administration decided to open an old unit in the 'receiving hospital' building to handle the overflow. The "Adult Transitional Shelter Care Unit" has a capacity of 20. Patients on this unit are considered to be ready for discharge and not in active treatment. Even though MSH is managing this unit as well as it can, it requires key management staff to provide supervision, pulls direct care staff from other crowded units, and necessitates occupation of a building that does not meet code requirements.

RECOMMENDATIONS

1) To the greatest degree possible pending implementation of a fully integrated "co-occurring disorders" continuum of care per guidelines being developed by AMDD:

(a) specifically identify in initial assessments each patient who has a co-occurring mental illness and chemical use disorder;

(b) develop treatment plans for these patients that integrate treatment for the co-occurring disorders;

(c) conduct all counseling and treatment activities within the structure of an integrated treatment plan.

MONTANA STATE HOSPITAL RESPONSE

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
MONTANA STATE HOSPITAL

JUDY MARTZ
GOVERNOR

EDWARD [illegible]BERG
HOSPITAL ADMINISTRATOR

STATE OF MONTANA

www.dphhs.state.mt.us
(406) 693-7000
FAX (406) 693-7069

PO Box 300
WARM SPRINGS, MT 59756-0300

February 2, 2004

Steve Cahill, Chair

Gene Haire, Executive Director
Mental Disabilities Board of Visitors
P.O. Box 201901
Helena, MT 59620-0803

Dear Members and Staff of the Board of Visitors,

On behalf of Montana State Hospital, thank you for providing us with the report on the Board's review of Montana State Hospital on November 13 and 14, 2003. We appreciated the opportunity to provide you with information about our services and welcome your feedback. Your report has been shared with our staff and will be helpful in our continuous quality improvement efforts.

As you know, we face significant issues regarding overcrowding and a limited budget. Our facility was designed for a patient population of 135, and our budget and staffing level was based on an anticipated average census of 175 for the fiscal year. Today, our census is 191, and has exceeded 200 patients on a number of recent occasions. It has been many years since we have received an increase in legislative appropriations, with any new money for mental health services going to fund community programs. Nonetheless, we are very proud of what we do and work very hard to provide excellent psychiatric services and to coordinate care with community providers. We are very pleased this was evident to Board Members and Staff during the site review. We have an excellent team of employees who are very dedicated to the population we serve and enjoy the opportunity to put new and innovative programs into place.

The Board made one recommendation in the Site Review Report:

> To the greatest degree possible pending implementation of a fully integrated "co-occurring disorders" continuum of care per guidelines being developed by AMDD:
>
> (a) Specifically identify in initial assessments each patient who has a co-occurring mental illness and chemical use disorder;
> *(b) Develop treatment plans for these patients that integrate treatment for the co-occurring disorders;*
> *(c) Conduct all counseling and treatment activities within the structure of an integrated treatment plan.*

Our response to this recommendation is as follows:

> Montana State Hospital recognizes the need and fully supports efforts to provide co-occurring treatment for our patients. Although the state commitment law provides a very specific definition of mental disorder that specifically excludes addiction to drugs or alcohol, or drug or alcohol intoxication (53-21-102(9) M.C.A.), we recognize that substance abuse or addiction is a major contributing factor to the admission of people to Montana State Hospital. We have been very active on the AMDD task force on co-occurring disorders and provide a significant amount of staff training on co-occurring treatment. A co-occurring "pathway" to guide this area of patient treatment is under development and we offer a number of group therapy and patient education programs on this topic.

We will continue to develop new services and integrate co-occurring services into our comprehensive treatment program. We agree this is an important need for both the Hospital and the state's mental health and chemical dependency treatment systems.

Again, thank you for your constructive feedback and for your efforts on behalf of people with serious mental illnesses.

Sincerely,

Edward Amberg

Edward Amberg
Hospital Administrator